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103D CONGRESS
2D SESSION

S. 1978

To amend part III of title 5, United States Code, to provide for participation by non-Federal employees in health benefits plans under the Federal Employees Health Benefits Program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 24 (legislative day, FEBRUARY 22), 1994

Mr. ROTH introduced the following bill; which was read twice and referred to the Committee on Governmental Affairs

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A BILL

To amend part III of title 5, United States Code, to provide for participation by non-Federal employees in health benefits plans under the Federal Employees Health Benefits Program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Federal Health Care Expansion Act of 1994".

SEC. 2. FINDINGS.

The Congress finds that—

(1) the United States spends more on health care than any other nation in the world, and costs continue to increase at double digit rates;

(2) more than 35,000,000 people in the United States do not have basic health care insurance;

(3) small businesses and the self-employed find it particularly difficult to obtain affordable health insurance because of the small-risk pools in which they are grouped; and

(4) the Federal Employees Health Benefits Program provides quality health care coverage nationwide while providing enrollees with a large degree of choice.

SEC. 3. PURPOSES.

The purposes of this Act are to—

(1) reduce the rising cost of health care through the use of market forces;

(2) increase access to affordable health care to millions of individuals who do not have health insurance;

(3) make available to millions of Americans the health care coverage that is available to the President, Members of Congress, Supreme Court Justices, members of the President's Cabinet, and millions of Federal employees and retirees;

(4) accomplish these purposes without the use of global spending caps, employer mandates, or the establishment of a huge Government bureaucracy; and

(5) strengthen the Federal Employees Health Benefits Program by introducing greater competition into the Federal employee plan so that the Government can use its power as a major purchaser of health care to drive down the costs of care for Federal enrollees while maintaining high quality care and service.

TITLE I—SMALL BUSINESS PARTICIPATION IN FEDERAL EMPLOYEES HEALTH BENEFITS PLANS

SEC. 101. SMALL BUSINESS PARTICIPATION IN FEDERAL EMPLOYEES HEALTH BENEFITS PLANS.

Part III of title 5, United States Code, is amended by inserting after chapter 89 the following new chapter:

"CHAPTER 90—SMALL BUSINESS PARTICIPATION IN FEDERAL EMPLOYEE HEALTH BENEFITS PLANS

"Sec.
"9001. Definition.
"9002. Application to small business participants.
"9003. Small business participation.
"9004. Contributions.
"9005. Continued coverage.

"9006. Schedule of small business participation.

"§ 9001. Definition

"For purposes of this chapter, the term 'small business' means any business entity which employs 100 or less employees (including businesses with one self-employed individual).

"§ 9002. Application to small business participants

"(a) The Office of Personnel Management shall promulgate regulations to apply the provisions of chapter 89, relating to health benefits plans, to the greatest extent practicable to small businesses and individuals covered under the provisions of this chapter.

"(b) Notwithstanding the provisions of subsection (a), carriers shall offer the same health benefits plans for the same premiums as are offered under chapter 89.

"(c) Notwithstanding subsection (a), the provisions of section 8907 shall not apply to individuals covered under this chapter, except the Office of Personnel Management shall establish a method to disseminate information relating to health benefits plans (including information concerning periods of open enrollment and a summary of the information described in section 8908) to such individuals through small business participants and carriers.

"§ 9003. Small business participation

"Any small business which desires to participate in a health benefits plan under this chapter may enter into

a contract with a carrier in accordance with this chapter. Such contract shall be for a term of no less than 1 year.

"§ 9004. Contributions

"(a) Subject to the provisions of subsection (b), an individual enrolled in a health benefits plan under this chapter shall make contributions equal to the amount of contributions made by—

"(1) a Federal enrollee in such plan under individual, or self and family coverage, as the case may be, as determined under section 8906; and

"(2) the Federal agency making Government contributions determined under section 8906 for such Federal enrollee.

"(b)(1) A small business may by contract agree to make any amount of the contribution required under subsection (a) on behalf of an enrollee under such subsection.

"(2) An agency of a State government may provide any amount of the contribution required under subsection (a) on behalf of an enrollee under such subsection.

"(3) The Secretary of Health and Human Services (HHS) may subsidize any amount of the contribution required by subsection (a) or section 9005(a) for any qualified enrollee of any small business participating in a health benefits plan under this chapter. For purposes of the preceding sentence, the term 'qualified enrollee' will be deter-

mined by the Secretary of HHS according to the number of individuals apply and the budget neutrality requirement in section 105 of this Act.

"(c) A small business participating under this chapter shall—

"(1) collect contributions from employees by withholdings from pay or by another method or schedule;

"(2) make payments of such contributions to the contracted carrier;

"(3) maintain and make available such records as the Office, applicable State insurance authority, or carrier may require; and

"(4) provide any other related administrative service in carrying out the provisions of this chapter.

"§ 9005. Continued coverage

"(a) Subject to subsection (b), the provisions of section 8905a shall be made applicable to enrollees and individuals covered by such enrollments under this chapter through section 9002 and the carrier contract entered into under section 9003, except the enrollee shall pay all contributions for continued coverage and the applicable amount for administrative expenses unless the applicable small business by contract agrees to pay any part of such contributions or expenses.

"(b) An individual may be covered under continued coverage as provided under subsection (a), only if such individual remains in the same plan during the period of continued coverage as such individual was enrolled in immediately before such period of continued coverage.

"§ 9006. Schedule of small business participation

"(a) Subject to the provisions of subsections (b), (c), (d), (e), and (f), each carrier enrolling individuals of small business participants under this chapter shall ensure that—

"(1) in the first contract year after the date of the enactment of the Federal Health Care Expansion Act of 1994, the number of enrollees from small businesses as provided under this chapter shall be no less than 5 percent of the number of Federal enrollees enrolled under chapter 89;

"(2) in the second such year, the number of small business enrollees shall be no less than 20 percent of the number of such Federal enrollees;

"(3) in the third such year, the number of small business enrollees shall be no less than 40 percent of the number of such Federal enrollees;

"(4) in the fourth such year, the number of small business enrollees shall be no less than 60 percent of the number of such Federal enrollees; and

"(5) in the fifth such year and in each year thereafter, the number of small business enrollees shall be no less than 80 percent of the number of such Federal enrollees.

"(b) Beginning in the contract year described under subsection (a)(1) and in each contract year thereafter, in no event shall a carrier enroll enrollees from less than 1 small business.

"(c)(1) In the contract year described under subsection (a)(1), a small business may participate if such business—

"(A) has between 75 and 100 employees; and

"(B) shall ensure that at least 80 percent of such employees shall enroll.

"(2) In the contract year described under subsection (a)(2) small businesses with between 50 and 74 employees may additionally participate.

"(3) In the contract year described under subsection (a)(3), small businesses with between 1 and 49 employees may additionally participate.

"(4) In the contract year described under subsection (a)(4) and each year thereafter, all small businesses may participate.

"(d) If during any contract year described under subsection (a) (1) through (5), more small businesses apply

for participation than are required to participate under such subsection, the carrier shall—

"(1) subject to paragraph (2), randomly select small businesses for participation from all applications; and

"(2) ensure that from such randomly selected small businesses, at least 50 percent of such businesses are not offering any type of health insurance benefits to its employees.

"(e) In the administration of subsection (a) (2) through (5) each carrier enrolling individuals of small business participants shall ensure that no less than 50 percent of small business enrollees in each contract year shall be individuals who had no health insurance coverage in the previous year.

"(f) A small business may participate in a health benefits plan as provided under this section if such business meets all such requirements otherwise provided under this chapter.

"(g) The Office may waive the requirements under subsection (a) but only after making a determination that there is insufficient interest in small businesses within the region in participating under this chapter.".

SEC. 102. EXTENSION OF CONTINUED COVERAGE.

Section 8905a of title 5, United States Code, is amended—

(1) in subsection (e)—

(A) in paragraph (1)(A) by striking out "18 months" and inserting in lieu thereof "36 months"; and

(B) in paragraph (2)(C) by striking out "18-month period" and inserting in lieu thereof "36-month period"; and

(2) in subsection (f)(3)(B) by striking out "18-month period" and inserting in lieu thereof "36-month period.

SEC. 103. COST EXPERIENCE COMPARISON REPORT.

No later than January 30 following the first contract year implementing the amendments made by section 101 of this Act, and on January 30 of each 4 years thereafter, each carrier contracting under chapter 89 or 90 of title 5, United States Code, shall submit a report to the Office of Personnel Management that compares the aggregate cost experiences with respect to coverage between—

(1) Federal employees and other individuals covered under chapter 89 of title 5, United States Code; and

(2) individuals covered under chapter 90 of such title.

SEC. 104. RISK ADJUSTMENT STUDY.

No later than 2 years after the date of the enactment of this Act, the Office of Personnel Management shall conduct a study and submit a health benefits plan risk adjustment report to the Congress. Such report shall examine in the administration of chapters 89 and 90 of title 5, United States Code (as amended and added by this Act)—

(1) the feasibility of risk adjusting premiums, by the use of subsidies and surcharges to hold carriers harmless for enrollment risks, based on demographic variables;

(2) the risk adjustment factors that are correlated with increased or diminished risk for consumption of the type of health services included in the standardized level of benefits established under such chapters;

(3) a formula for assigning numerical risk factors for lower than average risk for consumption of services, the average risk for consumption of services, and higher than average risk factors, and a methodology for the adjustment of such factors; and

(4) any recommendations for the enactment of legislation.

SEC. 105. ELIMINATION OF MEDICARE AND MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS TO FINANCE SELF-EMPLOYED DEDUCTION AND BUY-IN SUBSIDY.

(a) PHASE-OUT OF DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.—The Secretary of Health and Human Services shall phase-out over a 5-fiscal-year period beginning with the first fiscal year following the second January 1 described in section 107, the disproportionate share hospital payments under sections 1886(d)(5)(F) and 1902(a)(13)(A) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F) and 1396a(a)(13)(A)).

(b) BUDGET NEUTRAL MANNER.—The phase-out described in subsection (a) shall be accomplished in a Federal budget neutral manner such that the savings for each fiscal year resulting from such phase-out are fully used to offset the additional costs resulting from the amendments made by section 301 and section 201 of this Act and such costs resulting from the premium subsidy program for low-income workers of participating small businesses described in section 9003(b)(3) of title 5, United States Code (as added by section 101 of this Act).

(c) CONFORMING AMENDMENTS.—

(1) Clause (i) of section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) is amended by striking "For discharges" and inserting

"Except as provided in section 105 of the Federal Health Care Expansion Act of 1994, for discharges".

(2) Subparagraph (A) of section 1902(a)(13) of the Social Security Act (42 U.S.C. 1396a(a)(13)) is amended by striking "take into account the situation of hospitals" and inserting "take into account, except as provided in section 105 of the Federal Health Care Expansion Act of 1994, the situation of hospitals".

SEC. 106. STUDY REGARDING NONWORKER AND NONCOVERED EMPLOYEE BUY-INS.

The Secretary of Health and Human Services shall study by what method nonworkers and employees of employers not covered under chapter 90 of title 5, United States Code (as added by section 101 of this Act), may be incorporated into the buy-in for coverage under the Federal Employees Health Benefits Plan. The Secretary shall report the results of such study and any appropriate legislative recommendations to the Congress not later than 2 years after the date of the enactment of this Act.

SEC. 107. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided under subsection (b), the provisions of this Act and the amendments made by this Act shall be effective on and after the first

January 1, occurring after the date of the enactment of this Act.

(b) EXCEPTION.—The provisions of chapters 89 and 90 of title 5, United States Code, as amended and added by this title, relating to the establishment of or exercise of authority (including the promulgation of regulations) by the Office of Personnel Management, the Secretary of Health and Human Services, the President, or any other applicable Federal officer shall take effect on the date of the enactment of this Act in order to establish health benefits plans and fully implement the provisions and amendments made by this Act no later than the first January 1 occurring after the date of the enactment of this Act.

TITLE II—BETTER ACCESS TO AFFORDABLE HEALTH CARE

Subtitle A—Improvements in Health Insurance Affordability for Small Employers

SEC. 201. GRANTS TO STATES FOR SMALL EMPLOYER HEALTH INSURANCE PURCHASING PROGRAMS.

(a) IN GENERAL.—The Secretary of Health and Human Services (hereafter in this section referred to as the "Secretary") shall make grants to States that submit applications meeting the requirements of this section for

the establishment and operation of small employer health insurance purchasing programs.

(b) USE OF FUNDS.—Grant funds awarded under this section to a State may be used to finance administrative costs associated with developing and operating a group purchasing program for small employers, such as the costs associated with—

(1) engaging in marketing and outreach efforts to inform small employers about the group purchasing program, which may include the payment of sales commissions;

(2) negotiating with insurers to provide health insurance through the group purchasing program; or

(3) providing administrative functions, such as eligibility screening, claims administration, and customer service.

(c) APPLICATION REQUIREMENTS.—An application submitted by a State to the Secretary must describe—

(1) whether the program will be operated directly by the State or through one or more State-sponsored private organizations and the details of such operation;

(2) any participation requirements for small employers;

(3) the extent of insurance coverage among the eligible population, projections for change in the extent of such coverage, and the price of insurance currently available to these small employers;

(4) program goals for reducing the price of health insurance for small employers and increasing insurance coverage among employees of small employers and their dependents;

(5) the approaches proposed for enlisting participation by insurers and small employers, including any plans to use State funds to subsidize the cost of insurance for participating employers; and

(6) the methods proposed for evaluating the effectiveness of the program in reducing the number of uninsured in the State and on lowering the price of health insurance to small employers in the State.

(d) GRANT CRITERIA.—In awarding grants, the Secretary shall consider the potential impact of the State's proposal on the cost of health insurance for small employers and on the number of uninsured, and the need for regional variation in the awarding of grants. To the extent the Secretary deems appropriate, grants shall be awarded to fund programs employing a variety of approaches for establishing small employer health insurance group purchasing programs.

(e) PROHIBITION ON GRANTS.—No grant funds shall be paid to States that do not meet the requirements of title XXI of the Social Security Act with respect to small employer health insurance plans, or to States with group purchasing programs involving small employer health insurance plans that do not meet the requirements of such title.

(f) ANNUAL REPORT BY STATES.—States receiving grants under this section must report to the Secretary annually on the numbers and rates of participation by eligible insurers and small employers, on the estimated impact of the program on reducing the number of uninsured, and on the price of insurance available to small employers in the State.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each of fiscal years 1995, 1996, and 1997, such sums as may be necessary for the purposes of awarding grants under this section.

(h) SECRETARIAL REPORT.—The Secretary shall report to Congress by no later than January 1, 1997, on the number and amount of grants awarded under this section, and include with such report an evaluation of the impact of the grant program on the number of uninsured and price of health insurance to small employers in participating States.

Subtitle B—Improvements in Health Insurance for Small Employers

PART I—STANDARDS AND REQUIREMENTS OF SMALL EMPLOYER HEALTH INSURANCE REFORM

SEC. 211. STANDARDS AND REQUIREMENTS OF SMALL EMPLOYER HEALTH INSURANCE.

The Social Security Act is amended by adding at the end the following new title:

"TITLE XXI—STANDARDS FOR SMALL EMPLOYER HEALTH INSURANCE AND CERTIFICATION OF MANAGED CARE PLANS

"PART A—GENERAL STANDARDS; DEFINITIONS

"APPLICATION OF REQUIREMENTS TO SMALL EMPLOYER HEALTH INSURANCE PLANS

"SEC. 2101. (a) PLAN UNDER STATE REGULATORY PROGRAM OR CERTIFIED BY THE SECRETARY.—An insurer offering a health insurance plan to a small employer in a State on or after the effective date applicable to the State under subsection (b) shall be treated as meeting the requirements of this title if—

"(1) the Secretary determines that the State has established a regulatory program that provides for the application and enforcement of standards

meeting the requirements under section 2102 to meet the requirements of part B of this title; and

"(2) if the State has not established such a program or if the program has been decertified by the Secretary under section 2102(b), the health insurance plan has been certified by the Secretary (in accordance with such procedures as the Secretary establishes) as meeting the requirements of part B of this title.

"(b) EFFECTIVE DATES.—

"(1) IN GENERAL.—Except as specified in paragraph (2) and provided in paragraph (3), the standards established under section 2102 to meet the requirements of part B of this title shall apply to health insurance plans offered, issued, or renewed to a small employer in a State on or after January 1, 1995.

"(2) EXCEPTION FOR LEGISLATION.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

"(A) requiring State legislation (other than legislation appropriating funds) in order for insurers and health insurance plans offered to small employers to meet the standards under

the program established under subsection (a), or

"(B) having a legislature which does not meet in 1995 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first regular legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular legislative session of the State legislature.

"(3) REQUIREMENTS APPLIED TO EXISTING POLICIES.—In the case of a health insurance plan in effect before the applicable effective date specified in paragraph (1) or (2), the requirements referred to in subsections (a) and (b) of section 2112 shall not apply to any such plan, or any renewal of such plan, before the date which is 2 years after such effective date.

"(c) REPORTING REQUIREMENTS OF STATES.—Each State shall submit to the Secretary, at intervals established by the Secretary, a report on the implementation

and enforcement of the standards under the program established under subsection (a)(1) with respect to health insurance plans offered to small employers.

"(d) MORE STRINGENT STATE STANDARDS PERMITTED.—Except as provided in subsections (b)(8) and (c)(4) of section 2113, a State may implement standards that are more stringent than the standards established to meet the requirements of part B of this title.

"(e) LIMITED WAIVER OF RATING REQUIREMENTS.—The Secretary may waive requirements with respect to subsections (b) and (e) of section 2112 in the case of a State with equally stringent but not identical standards in effect prior to January 1, 1994.

"ESTABLISHMENT OF STANDARDS

"SEC. 2102. (a) ESTABLISHMENT OF STANDARDS.—

"(1) ROLE OF THE NAIC.—The Secretary shall request that the NAIC—

"(A) develop specific standards, in the form of a model Act and model regulations, to implement the requirements of part B of this title; and

"(B) report to the Secretary on such standards,

by not later than September 30, 1994. If the NAIC develops such standards within such period and the Secretary finds that such standards implement the

requirements of part B of this title, such standards shall be the standards applied under section 2101.

"(2) ROLE OF THE SECRETARY.—If the NAIC fails to develop and report on the standards described in paragraph (1) by the date specified in such paragraph or the Secretary finds that such standards do not implement the requirements under part B of this title, the Secretary shall develop and publish such standards, by not later than December 31, 1994. Such standards shall then be the standards applied under section 2101.

"(3) STANDARDS ON GUARANTEED AVAILABILITY.—The standards developed under paragraphs (1) and (2) shall provide alternative standards for guaranteeing availability of health insurance plans for all small employers in a State as provided in section 2111(c).

"(4) GUIDELINES FOR DEMOGRAPHIC RATING FACTORS.—The standards developed under paragraphs (1) and (2) shall include guidelines with respect to rating factors used by insurers to adjust premiums to reflect demographic characteristics of a small employer group.

"(b) PERIODIC SECRETARIAL REVIEW OF STATE REGULATORY PROGRAM.—The Secretary periodically

shall review State regulatory programs to determine if they continue to meet and enforce the standards referred to in subsection (a). If the Secretary initially determines that a State regulatory program no longer meets and enforces such standards, the Secretary shall provide the State an opportunity to adopt a plan of correction that would bring such program into compliance with such standards. If the Secretary makes a final determination that the State regulatory program fails to meet and enforce such standards and requirements after such an opportunity, the Secretary shall decertify such program and assume responsibility under section 2101(a)(2) with respect to plans in the State.

"(c) GAO AUDITS.—The Comptroller General of the United States shall conduct periodic reviews on a sample of State regulatory programs to determine their compliance with the standards and requirements of this title. The Comptroller General of the United States shall report to the Secretary and Congress on the findings of such reviews.

"DEFINITIONS

"SEC. 2103. (a) HEALTH INSURANCE PLAN.—As used in this title, the term 'health insurance plan' means any hospital or medical service policy or certificate, hospital or medical service plan contract, health maintenance

organization group contract, or a multiple employer welfare arrangement, but does not include—

"(1) a self-insured group health plan;

"(2) a self-insured multiemployer group health plan; or

"(3) any of the following offered by an insurer—

"(A) accident only, dental only, vision only, disability only insurance, or long-term care only insurance,

"(B) coverage issued as a supplement to liability insurance,

"(C) medicare supplemental insurance as defined in section 1882(g)(1),

"(D) workmen's compensation or similar insurance, or

"(E) automobile medical-payment insurance.

In the case of a multiple employer welfare arrangement that is fully insured, the requirements of this Act shall only apply to the insurer of the arrangement.

"(b) INSURER.—As used in this title the term 'insurer' means any person that offers a health insurance plan to a small employer.

"(c) GENERAL DEFINITIONS.—As used in this title:

"(1) APPLICABLE REGULATORY AUTHORITY.—The term 'applicable regulatory authority' means—

"(A) in the case of a health insurance plan offered in a State with a program meeting the requirements of part B of this title, the State commissioner or superintendent of insurance or other State authority responsible for regulation of health insurance; or

"(B) in the case of a health insurance plan certified by the Secretary under section 2101(a)(2), the Secretary.

"(2) SMALL EMPLOYER.—The term 'small employer' means, with respect to a calendar year, an employer that normally employs more than 1 but less than 101 eligible employees on a typical business day. For the purposes of this paragraph, the term 'employee' includes a self-employed individual.

"(3) ELIGIBLE EMPLOYEE.—The term 'eligible employee' means, with respect to an employer, an employee who normally performs on a monthly basis at least 30 hours of service per week for that employer.

"(4) NAIC.—The term 'NAIC' means the National Association of Insurance Commissioners.

"(5) STATE.—The term 'State' means each of the several States, the District of Columbia, and the Commonwealth of Puerto Rico.

"PART B—SMALL EMPLOYER HEALTH INSURANCE REFORM

"GENERAL REQUIREMENTS FOR HEALTH INSURANCE PLANS ISSUED TO SMALL EMPLOYERS

"SEC. 2111. (a) REGISTRATION WITH APPLICABLE REGULATORY AUTHORITY.—Each insurer shall register with the applicable regulatory authority for each State in which it issues or offers a health insurance plan to small employers.

"(b) GUARANTEED ELIGIBILITY.—

"(1) IN GENERAL.—No insurer may exclude from coverage any eligible employee, or the spouse or any dependent child of the eligible employee, to whom coverage is made available by a small employer.

"(2) WAITING PERIODS.—Paragraph (1) shall not apply to any period an eligible employee is excluded from coverage under the health insurance plan solely by reason of a requirement imposed by an employer applicable to all employees that a minimum period of service with the small employer is re-

quired before the employee is eligible for such coverage.

"(c) GUARANTEED AVAILABILITY.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, an insurer that offers a health insurance plan to small employers located in a State must meet the standards adopted by the State described in paragraph (2).

"(2) STANDARDS ON GUARANTEED AVAILABILITY.—

"(A) IN GENERAL.—In order to implement the requirements of this title, the standards developed under paragraphs (1) and (2) of section 2102(a) shall—

"(i) require that a State adopt a mechanism for guaranteeing the availability of health insurance plans for all small employers in the State,

"(ii) specify alternative mechanisms, including at least the alternative mechanisms described in subparagraph (B), that a State may adopt, and

"(iii) prohibit marketing or other practices by an insurer intended to discourage or limit the issuance of a health

insurance plan to a small employer on the basis of size, industry, geographic area, expected need for health services, or other risk factors.

"(B) ALTERNATIVE MECHANISMS.—The alternative mechanisms described in this subparagraph are:

"(i) A mechanism under which the State—

"(I) requires that any insurer offering a health insurance plan to a small employer in the State shall offer the same plan to all other small employers in the State or in the portion of the State established as the insurer's geographic service area (as approved by the State), and

"(II) requires the participation of all such insurers in a small employer reinsurance program established by the State.

"(ii) A mechanism under which the State—

"(I) requires that any insurer offering a health insurance plan to a

small employer in the State shall offer the same plan to all other small employers in the State or in the portion of the State established as the insurer's geographic service area (as approved by the State), and

"(II) permits any such insurer to participate in a small employer reinsurance program established by the State.

"(iii) A mechanism under which the State requires that any insurer offering a health insurance plan to a small employer in the State shall participate in a program for assigning high-risk groups among all such insurers.

"(iv) A mechanism under which the State requires that any insurer that—

"(I) offers a health insurance plan to a small employer in the State, and

"(II) does not agree to offer the same plan to all other small employers in the State or in the portion of the State established as the insurer's geo-

graphic service area (as approved by the State),

shall participate in a program for assigning high-risk groups among all such insurers.

"(C) STATE ADOPTION OF CERTAIN STANDARDS.—A regulatory program adopted by the State under section 2101 must provide—

"(i) for the adoption of one of the mechanisms described in clauses (i) through (iv) of subparagraph (B), or

"(ii) for such other program that guarantees availability of health insurance to all small employers in the State and is approved by the Secretary.

"(D) STANDARDS FOR NONCOMPLYING STATES.—The Secretary, in consultation with the Secretary of the Treasury, shall develop requirements with respect to guaranteed availability to apply with respect to insurers located in a State that has not adopted the standards under section 2102 and who wish to apply for certification under section 2101(a)(2).

"(3) GROUNDS FOR REFUSAL TO RENEW.—

"(A) IN GENERAL.—An insurer may refuse to renew, or (except with respect to clause (iii)) may terminate, a health insurance plan under this part only for—

"(i) nonpayment of premiums,

"(ii) fraud or misrepresentation,

"(iii) failure to maintain minimum participation rates (consistent with subparagraph (B)), or

"(iv) repeated misuse of a provider network provision.

"(B) MINIMUM PARTICIPATION RATES.—An insurer may require, with respect to a health insurance plan issued to a small employer, that a minimum percentage of eligible employees who do not otherwise have health insurance are enrolled in such plan if such percentage is applied uniformly to all plans offered to employers of comparable size.

"(d) GUARANTEED RENEWABILITY.—

"(1) IN GENERAL.—An insurer shall ensure that a health insurance plan issued to a small employer be renewed, at the option of the small employer, unless the plan is terminated for a reason specified in paragraph (2) or in subsection (c)(3)(A).

"(2) TERMINATION OF SMALL EMPLOYER BUSINESS.—An insurer is not required to renew a health insurance plan with respect to a small employer if the insurer—

"(A) elects not to renew all of its health insurance plans issued to small employers in a State; and

"(B) provides notice to the applicable regulatory authority in the State and to each small employer covered under a plan of such termination at least 180 days before the date of expiration of the plan.

In the case of such a termination, the insurer may not provide for issuance of any health insurance plan to a small employer in the State during the 5-year period beginning on the date of termination of the last plan not so renewed.

"(e) NO DISCRIMINATION BASED ON HEALTH STATUS FOR CERTAIN SERVICES.—

"(1) IN GENERAL.—Except as provided under paragraph (2), a health insurance plan offered to a small employer by an insurer may not deny, limit, or condition the coverage under (or benefits of) the plan based on the health status, claims experience,

receipt of health care, medical history, or lack of evidence of insurability, of an individual.

"(2) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, a health insurance plan offered to a small employer by an insurer may exclude coverage with respect to services related to treatment of a preexisting condition, but the period of such exclusion may not exceed 6 months. The exclusion of coverage shall not apply to services furnished to newborns.

"(B) CREDITING OF PREVIOUS COVERAGE.—

"(i) IN GENERAL.—A health insurance plan issued to a small employer by an insurer shall provide that if an individual under such plan is in a period of continuous coverage (as defined in clause (ii)(I)) with respect to particular services as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced

by 1 month for each month in the period of continuous coverage.

"(ii) DEFINITIONS.—As used in this subparagraph:

"(I) PERIOD OF CONTINUOUS COVERAGE.—The term 'period of continuous coverage' means, with respect to particular services, the period beginning on the date an individual is enrolled under a health insurance plan, title XVIII, title XIX, or other health benefit arrangement including a self-insured plan which provides benefits with respect to such services and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

"(II) PREEXISTING CONDITION.—The term 'preexisting condition' means, with respect to coverage under a health insurance plan issued to a small employer by an insurer, a condition which has been diagnosed or treated during the 3-month period ending on the day before the first date

of such coverage (without regard to any waiting period).

"REQUIREMENTS RELATED TO RESTRICTIONS ON RATING PRACTICES

"SEC. 2112. (a) LIMIT ON VARIATION OF PREMIUMS BETWEEN BLOCKS OF BUSINESS.—

"(1) IN GENERAL.—The base premium rate for any block of business of an insurer (as defined in section 2103(b)(1)) may not exceed the base premium rate for any other block of business by more than 20 percent.

"(2) EXCEPTIONS.—Paragraph (1) shall not apply to a block of business if the applicable regulatory authority determines that—

"(A) the block is one for which the insurer does not reject, and never has rejected, small employers included within the definition of employers eligible for the block of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claims experience, health status, industry, or occupation,

"(B) the insurer does not transfer, and never has transferred, a health insurance plan involuntarily into or out of the block of business, and

"(C) health insurance plans offered under the block of business are currently available for purchase by small employers at the time an exception to paragraph (1) is sought by the insurer.

"(b) LIMIT ON VARIATION IN PREMIUM RATES WITHIN A BLOCK OF BUSINESS.—For a block of business of an insurer, the highest premium rates charged during a rating period to small employers with similar demographic characteristics (limited to age, sex, family size, and geography and not relating to claims experience, health status, industry, occupation, or duration of coverage since issue) for the same or similar coverage, or the highest rates which could be charged to such employers under the rating system for that block of business, shall not exceed an amount that is 1.5 times the base premium rate for the block of business for a rating period (or portion thereof) that occurs in the first 3 years in which this section is in effect, and 1.35 times the base premium rate thereafter.

"(c) CONSISTENT APPLICATION OF RATING FACTORS.—In establishing premium rates for health insurance plans offered to small employers—

"(1) an insurer making adjustments with respect to age, sex, family size, or geography must

apply such adjustments consistently across small employers (as provided in guidelines developed under section 2102(a)(4)), and

"(2) no insurer may use a geographic area that is smaller than a county or smaller than an area that includes all areas in which the first three digits of the zip code are identical, whichever is smaller.

"(d) LIMIT ON TRANSFER OF EMPLOYERS AMONG BLOCKS OF BUSINESS.—

"(1) IN GENERAL.—An insurer may not transfer a small employer from one block of business to another without the consent of the employer.

"(2) OFFERS TO TRANSFER.—An insurer may not offer to transfer a small employer from one block of business to another unless—

"(A) the offer is made without regard to age, sex, geography, claims experience, health status, industry, occupation or the date on which the policy was issued, and

"(B) the same offer is made to all other small employers in the same block of business.

"(e) LIMITS ON VARIATION IN PREMIUM INCREASES.—The percentage increase in the premium rate charged to a small employer for a new rating period (determined on an annual basis) may not exceed the sum of

the percentage change in the base premium rate plus 5 percentage points.

"(f) DEFINITIONS.—In this section:

"(1) BASE PREMIUM RATE.—The term 'base premium rate' means, for each block of business for each rating period, the lowest premium rate which could have been charged under a rating system for that block of business by the insurer to small employers with similar demographic or other relevant characteristics (limited to age, sex, family size, and geography and not relating to claims experience, health status, industry, occupation or duration of coverage since issue) for health insurance plans with the same or similar coverage.

"(2) BLOCK OF BUSINESS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'block of business' means, with respect to an insurer, all of the small employers with a health insurance plan issued by the insurer (as shown on the records of the insurer).

"(B) DISTINCT GROUPS.—

"(i) IN GENERAL.—Subject to clause (ii), a distinct group of small employers with health insurance plans issued by an

insurer may be treated as a block of business by such insurer if all of the plans in such group—

"(I) are marketed and sold through individuals and organizations that do not participate in the marketing or sale of other distinct groups by the insurer,

"(II) have been acquired from another insurer as a distinct group, or

"(III) are provided through an association with membership of not less than 25 small employers that has been formed for purposes other than obtaining health insurance.

"(ii) LIMITATION.—An insurer may not establish more than six distinct groups of small employers.

"(f) FULL DISCLOSURE OF RATING PRACTICES.—

"(1) IN GENERAL.—At the time an insurer offers a health insurance plan to a small employer, the insurer shall fully disclose to the employer all of the following:

"(A) Rating practices for small employer health insurance plans, including rating prac-

tices for different populations and benefit designs.

"(B) The extent to which premium rates for the small employer are established or adjusted based upon the actual or expected variation in claims costs or health condition of the employees of such small employer and their dependents.

"(C) The provisions concerning the insurer's right to change premium rates, the extent to which premiums can be modified, and the factors which affect changes in premium rates.

"(2) NOTICE ON EXPIRATION.—An insurer providing health insurance plans to small employers shall provide for notice, at least 60 days before the date of expiration of the health insurance plan, of the terms for renewal of the plan. Such notice shall include an explanation of the extent to which any increase in premiums is due to actual or expected claims experience of the individuals covered under the small employer's health insurance plan contract.

"(g) ACTUARIAL CERTIFICATION.—Each insurer shall file annually with the applicable regulatory authority a written statement by a member of the American Academy of Actuaries (or other individual acceptable to such

authority) certifying that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of the insurer and methods used by the insurer in establishing premium rates for small employer health insurance plans—

"(1) the insurer is in compliance with the applicable provisions of this section, and

"(2) the rating methods are actuarially sound.

Each insurer shall retain a copy of such statement for examination at its principal place of business.

"REQUIREMENTS FOR SMALL EMPLOYER HEALTH INSURANCE BENEFIT PACKAGE OFFERINGS

"SEC. 2113. (a) BASIC AND STANDARD BENEFIT PACKAGES.—

"(1) IN GENERAL.—If an insurer offers any health insurance plan to small employers in a State, the insurer shall also offer a health insurance plan providing for the standard benefit package defined in subsection (b) and a health insurance plan providing for the basic benefit package defined in subsection (c).

"(2) MANAGED CARE OPTION.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), if an insurer offers any health insurance plan to small employers in a State and also offers a managed care plan in

the State or a geographic area within the State to employers that are not small employers, the insurer must offer a similar managed care plan to small employers in the State or geographic area.

"(B) SIZE LIMITS.—An insurer may cease enrolling new small employer groups in all or a portion of the insurer's service area for a managed care plan if it ceases to enroll any new employer groups within the service area or within a portion of a service area of such plan.

"(b) STANDARD BENEFIT PACKAGE.—

"(1) IN GENERAL.—

"(A) PACKAGE DEFINED.—Except as otherwise provided in this section, a health insurance plan providing for a standard benefit package shall be limited to payment for—

"(i) inpatient and outpatient hospital care, except that treatment for a mental disorder, as defined in subparagraph (B)(i), is subject to the special limitations described in clause (v)(I);

"(ii) inpatient and outpatient physician services, as defined in subparagraph (B)(ii), except that psychotherapy or coun-

seling for a mental disorder is subject to the special limitations described in clause (v)(II);

"(iii) diagnostic tests;

"(iv) preventive services limited to—

"(I) prenatal care and well-baby care provided to children who are 1 year of age or younger;

"(II) well-child care;

"(III) Pap smears;

"(IV) mammograms; and

"(V) colorectal screening services; and

"(v)(I) inpatient hospital care for a mental disorder for not less than 45 days per year, except that days of partial hospitalization or residential care may be substituted for days of inpatient care; and

"(II) outpatient psychotherapy and counseling for a mental disorder for not less than 20 visits per year provided by a provider who is acting within the scope of State law and who—

"(aa) is a physician; or

"(bb) is a duly licensed or certified clinical psychologist or a duly licensed or certified clinical social worker, a duly licensed or certified equivalent mental health professional, or a clinic or center providing duly licensed or certified mental health services.

"(B) DEFINITIONS.—For purposes of this paragraph:

"(i) MENTAL DISORDER.—The term 'mental disorder' has the same meaning given such term in the International Classification of Diseases, 9th Revision, Clinical Modification.

"(ii) PHYSICIAN SERVICES.—The term 'physician services' means professional medical services lawfully provided by a physician under State medical practice acts, and includes professional services provided by a dentist, licensed advanced-practice nurse, physician assistant, optometrist, podiatrist, or chiropractor acting within the scope of their practices (as determined under State law) if such services

would be treated as physician services if furnished by a physician.

"(2) AMOUNT, SCOPE, AND DURATION OF CERTAIN BENEFITS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B) and in paragraph (3), a health insurance plan providing for a standard benefit package shall place no limits on the amount, scope, or duration of benefits described in subparagraphs (A) through (C) of paragraph (1).

"(B) PREVENTIVE SERVICES.—A health insurance plan providing for a standard benefit package may limit the amount, scope, and duration of preventive services described in subparagraph (D) of paragraph (1) provided that the amount, scope, and duration of such services are reasonably consistent with recommendations and periodicity schedules developed by appropriate medical experts.

"(3) EXCEPTIONS.—Paragraph (1) shall not be construed as requiring a plan to include payment for—

"(A) items and services that are not medically necessary;

"(B) routine physical examinations or preventive care (other than care and services described in subparagraph (D) of paragraph (1)); or

"(C) experimental services and procedures.

"(4) LIMITATION ON PREMIUMS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), an insurer issuing a health insurance plan providing for a standard benefit package shall not require an employee to pay a monthly premium which exceeds 20 percent of the total monthly premium.

"(B) PART-TIME EMPLOYEE EXCEPTED.—In the case of a part-time employee, an insurer issuing a health insurance plan providing for a standard benefit package may require that such an employee pay a monthly premium that does not exceed 50 percent of the total monthly premium.

"(5) LIMITATION ON DEDUCTIBLES.—

"(A) IN GENERAL.—Except as permitted under subparagraph (B), a health insurance plan providing for a standard benefit package shall not provide a deductible amount for benefits provided in any plan year that exceeds—

"(i) with respect to benefits payable for items and services furnished to any employee with no family member enrolled under the plan, for a plan year beginning in—

"(I) a calendar year prior to 1995, $400; or

"(II) for a subsequent calendar year, the limitation specified in this clause for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year; and

"(ii) with respect to benefits payable for items and services furnished to any employee with a family member enrolled under the standard benefit package plan, for a plan year beginning in—

"(I) a calendar year prior to 1995, $400 per family member and $700 per family; or

"(II) for a subsequent calendar year, the limitation specified in this clause for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the limitation computed under clause (i)(II) or (ii)(II) is not a multiple of $10, it shall be rounded to the next highest multiple of $10.

"(B) WAGE-RELATED DEDUCTIBLE.—A health insurance plan may provide for any other deductible amount instead of the limitations under—

"(i) subparagraph (A)(i), if such amount does not exceed (on an annualized basis) 1 percent of the total wages paid to the employee in the plan year; or

"(ii) subparagraph (A)(ii), if such amount does not exceed (on an annualized basis) 1 percent per family member or 2

percent per family of the total wages paid to the employee in the plan year.

"(6) LIMITATION ON COPAYMENTS AND COINSURANCE.—

"(A) IN GENERAL.—Subject to subparagraphs (B) through (D), a health insurance plan providing for a standard health benefit package may not require the payment of any copayment or coinsurance for an item or service for which coverage is required under this section—

"(i) in an amount that exceeds 20 percent of the amount payable for the item or service under the plan; or

"(ii) after an employee and family covered under the plan have incurred out-of-pocket expenses under the plan that are equal to the out-of-pocket limit (as defined in subparagraph (E)(ii)) for a plan year.

"(B) EXCEPTION FOR MANAGED CARE PLANS.—A health insurance plan that is a managed care plan may require payments in excess of the amount permitted under subparagraph (A) in the case of items and services furnished by nonparticipating providers.

"(C) EXCEPTION FOR IMPROPER UTILIZATION.—A health insurance plan may provide for copayment or coinsurance in excess of the amount permitted under subparagraph (A) for any item or service that an individual obtains without complying with procedures established by a managed care plan or under a utilization program to ensure the efficient and appropriate utilization of covered services.

"(D) EXCEPTIONS FOR MENTAL HEALTH CARE.—In the case of care described in paragraph (1)(E)(ii), a health insurance plan shall not require payment of any copayment or coinsurance for an item or service for which coverage is required by this part in an amount that exceeds 50 percent of the amount payable for the item or service.

"(7) LIMIT ON OUT-OF-POCKET EXPENSES.—

"(A) OUT-OF-POCKET EXPENSES DEFINED.—As used in this section, the term 'out-of-pocket expenses' means, with respect to an employee in a plan year, amounts payable under the plan as deductibles and coinsurance with respect to items and services provided under the plan and furnished in the plan year on behalf

of the employee and family covered under the plan.

"(B) OUT-OF-POCKET LIMIT DEFINED.—As used in this section and except as provided in subparagraph (C), the term 'out-of-pocket limit' means for a plan year beginning in—

"(i) a calendar year prior to 1995, $3,000; or

"(ii) for a subsequent calendar year, the limit specified in this subparagraph for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the limit computed under clause (ii) is not a multiple of $10, it shall be rounded to the next highest multiple of $10.

"(C) ALTERNATIVE OUT-OF-POCKET LIMIT.—A health insurance plan may provide for an out-of-pocket limit other than that defined in subparagraph (B) if, for a plan year with respect to an employee and the family of

the employee, the limit does not exceed (on an annualized basis) 10 percent of the total wages paid to the employee in the plan year.

"(8) LIMITED PREEMPTION OF STATE MANDATED BENEFITS.—No State law or regulation in effect in a State that requires health insurance plans offered to small employers in the State to include specified items and services other than those specified by this subsection shall apply with respect to a health insurance plan providing for a standard benefit package offered by an insurer to a small employer. A State law or regulation requiring the coverage of newborns, adopted children or other specified categories of dependents shall continue to apply.

"(c) BASIC BENEFITS PACKAGE.—

"(1) IN GENERAL.—A health insurance plan providing for a basic benefit package shall be limited to payment for—

"(A) inpatient and outpatient hospital care, including emergency services;

"(B) inpatient and outpatient physicians' services;

"(C) diagnostic tests; and

"(D) preventive services (which may include one or more of the following services)—

"(i) prenatal care and well-baby care provided to children who are 1 year of age or younger;

"(ii) well-child care;

"(iii) Pap smears;

"(iv) mammograms; and

"(v) colorectal screening services.

Nothing in this paragraph shall prohibit a basic health benefit package from including coverage for treatment of a mental disorder.

"(2) COST-SHARING.—Each health insurance plan providing for the basic benefit package issued to a small employer by an insurer may impose premiums, deductibles, copayments, or other cost-sharing on enrollees of such plan.

"(3) OUT-OF-POCKET LIMIT.—Each health insurance plan providing for a basic benefit package shall provide for a limit on out-of-pocket expenses.

"(4) LIMITED PREEMPTION OF STATE MANDATED BENEFITS.—No State law or regulation in effect in a State that requires health insurance plans offered to small employers in the State to include specified items and services other than those described in this subsection shall apply with respect to a health insurance plan providing for a basic benefit

package offered by an insurer to a small employer. A State law or regulation requiring the coverage of newborns, adopted children or other specified categories of dependents shall continue to apply.".

PART II—TAX PENALTY ON NONCOMPLYING INSURERS

SEC. 221. EXCISE TAX ON PREMIUMS RECEIVED ON HEALTH INSURANCE POLICIES WHICH DO NOT MEET CERTAIN REQUIREMENTS.

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to taxes on group health plans) is amended by adding at the end thereof the following new section:

"SEC. 5000A. FAILURE TO SATISFY CERTAIN STANDARDS FOR HEALTH INSURANCE.

"(a) GENERAL RULE.—In the case of any person issuing a health insurance plan to a small employer, there is hereby imposed a tax on the failure of such person to meet at any time during any taxable year the applicable requirements of title XXI of the Social Security Act. The Secretary of Health and Human Services shall determine whether any person meets the requirements of such title.

"(b) AMOUNT OF TAX.—

"(1) IN GENERAL.—The amount of tax imposed by subsection (a) by reason of 1 or more failures

during a taxable year shall be equal to 25 percent of the gross premiums received during such taxable year with respect to all health insurance plans issued to a small employer by the person on whom such tax is imposed.

"(2) GROSS PREMIUMS.—For purposes of paragraph (1), gross premiums shall include any consideration received with respect to any accident and health insurance contract.

"(3) CONTROLLED GROUPS.—For purposes of paragraph (1)—

"(A) CONTROLLED GROUP OF CORPORATIONS.—All corporations which are members of the same controlled group of corporations shall be treated as 1 person. For purposes of the preceding sentence, the term 'controlled group of corporations' has the meaning given to such term by section 1563(a), except that—

"(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears in section 1563(a)(1), and

"(ii) the determination shall be made without regard to subsections (a)(4) and (e)(3)(C) of section 1563.

"(B) PARTNERSHIPS, PROPRIETORSHIPS, ETC., WHICH ARE UNDER COMMON CONTROL.—Under regulations prescribed by the Secretary, all trades or business (whether or not incorporated) which are under common control shall be treated as 1 person. The regulations prescribed under this subparagraph shall be based on principles similar to the principles which apply in the case of subparagraph (A).

"(c) LIMITATION ON TAX.—

"(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) with respect to any failure for which it is established to the satisfaction of the Secretary that the person on whom the tax is imposed did not know, and exercising reasonable diligence would not have known, that such failure existed.

"(2) TAX NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

"(A) such failure was due to reasonable cause and not to willful neglect, and

"(B) such failure is corrected during the 30-day period beginning on the 1st date any of the persons on whom the tax is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

"(3) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

"(d) DEFINITIONS.—For purposes of this section:

"(1) HEALTH INSURANCE PLAN.—The term 'health insurance plan' means any hospital or medical service policy or certificate, hospital or medical service plan contract, health maintenance organization group contract, or a multiple employer welfare arrangement, but does not include—

"(A) a self-insured group health plan;

"(B) a self-insured multiemployer group health plan; or

"(C) any of the following:

"(i) accident only, dental only, vision only, disability only, or long-term care only insurance,

"(ii) coverage issued as a supplement to liability insurance,

"(iii) medicare supplemental insurance as defined in section 1882(g)(1),

"(iv) workmen's compensation or similar insurance, or

"(v) automobile medical-payment insurance.

In the case of a multiple employer welfare arrangement that is fully insured, this Act shall only apply to the insurer of the arrangement.

"(2) SMALL EMPLOYER.—The term 'small employer' means, with respect to a calendar year, an employer that normally employs more than 1 but less than 101 eligible employees on a typical business day. For the purposes of this paragraph, the term 'employee' includes a self-employed individual.

"(3) ELIGIBLE EMPLOYEE.—The term 'eligible employee' means, with respect to an employer, an employee who normally performs on a monthly basis at least 30 hours of service per week for that employer.

"(4) PERSON.—The term 'person' means any person that offers a health insurance plan to a small employer, including a licensed insurance company, a

prepaid hospital or medical service plan, a health maintenance organization, or in States which have distinct insurance licensure requirements, a multiple employer welfare arrangement.".

(b) NONDEDUCTIBILITY OF TAX.—Paragraph (6) of section 275(a) of the Internal Revenue Code of 1986 (relating to nondeductibility of certain taxes) is amended by inserting "47," after "46,".

(c) CLERICAL AMENDMENTS.—The table of sections for such chapter 47 of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new item:

"Sec. 5000A. Failure to satisfy certain standards for health insurance.".

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a) and (c) shall take effect on the date of the enactment of this Act.

(2) NONDEDUCTIBILITY OF TAX.—The amendment made by subsection (b) shall apply to taxable years beginning after December 31, 1993.

PART III—STUDIES AND REPORTS

SEC. 231. GAO STUDY AND REPORT ON RATING REQUIREMENTS AND BENEFIT PACKAGES FOR SMALL GROUP HEALTH INSURANCE.

(a) IN GENERAL.—The Comptroller General of the United States shall study and report to the Congress by no later than January 1, 1996, on—

(1) the impact of the standards for rating practices for small group health insurance established under section 2112 of the Social Security Act and the requirements for benefit packages established under section 2113 of such Act on the availability and price of insurance offered to small employers, differences in available benefit packages, the number of small employers choosing standard or basic packages, and the impact of the standards on the number of small employers offering health insurance to employees through a self-funded employer welfare benefit plan; and

(2) differences in State laws and regulations affecting the availability and price of health insurance plans sold to individuals and the impact of such laws and regulations, including the extension of requirements for health insurance plans sold to small employers in the State to individual health insurance

and the establishment of State risk pools for individual health insurance.

(b) RECOMMENDATIONS.—The Comptroller General shall include in the report to Congress under this section recommendations with respect to adjusting rating standards under section 2112 of the Social Security Act—

(1) to eliminate variation in premiums charged to small employers resulting from adjustments for such factors as claims experience and health status, and

(2) to eliminate variation in premiums associated with age, sex, and other demographic factors.

Subtitle C—Improvements in Portability of Private Health Insurance

SEC. 241. EXCISE TAX IMPOSED ON FAILURE TO PROVIDE FOR PREEXISTING CONDITION.

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to taxes on group health plans), as amended by section 221, is amended by adding at the end thereof the following new section:

"SEC. 5000B. FAILURE TO SATISFY PREEXISTING CONDITION REQUIREMENTS OF GROUP HEALTH PLANS.

"(a) GENERAL RULE.—There is hereby imposed a tax on the failure of—

"(1) a group health plan to meet the requirements of subsection (e), or

"(2) any person to meet the requirements of subsection (f),

with respect to any covered individual.

"(b) AMOUNT OF TAX.—

"(1) IN GENERAL.—The amount of the tax imposed by subsection (a) on any failure with respect to a covered individual shall be $100 for each day in the noncompliance period with respect to such failure.

"(2) NONCOMPLIANCE PERIOD.—For purposes of this section, the term 'noncompliance period' means, with respect to any failure, the period—

"(A) beginning on the date such failure first occurs, and

"(B) ending on the date such failure is corrected.

"(3) CORRECTION.—A failure of a group health plan to meet the requirements of subsection (e) with

respect to any covered individual shall be treated as corrected if—

"(A) such failure is retroactively undone to the extent possible, and

"(B) the covered individual is placed in a financial position which is as good as such individual would have been in had such failure not occurred.

For purposes of applying subparagraph (B), the covered individual shall be treated as if the individual had elected the most favorable coverage in light of the expenses incurred since the failure first occurred.

"(c) LIMITATIONS ON AMOUNT OF TAX.—

"(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) on any failure during any period for which it is established to the satisfaction of the Secretary that none of the persons referred to in subsection (d) knew, or exercising reasonable diligence would have known, that such failure existed.

"(2) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) on any failure if—

"(A) such failure was due to reasonable cause and not to willful neglect, and

"(B) such failure is corrected during the 30-day period beginning on the first date any of the persons referred to in subsection (d) knew, or exercising reasonable diligence would have known, that such failure existed.

"(3) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

"(d) LIABILITY FOR TAX.—

"(1) IN GENERAL.—Except as otherwise provided in this subsection, the following shall be liable for the tax imposed by subsection (a) on a failure:

"(A) In the case of a group health plan other than a self-insured group health plan, the issuer.

"(B)(i) In the case of a self-insured group health plan other than a multiemployer group health plan, the employer.

"(ii) In the case of a self-insured multiemployer group health plan, the plan.

"(C) Each person who is responsible (other than in a capacity as an employee) for administering or providing benefits under the group health plan, health insurance plan, or other health benefit arrangement (including a self-insured plan) and whose act or failure to act caused (in whole or in part) the failure.

"(2) SPECIAL RULES FOR PERSONS DESCRIBED IN PARAGRAPH (1)(C).—A person described in subparagraph (C) (and not in subparagraphs (A) and (B)) of paragraph (1) shall be liable for the tax imposed by subsection (a) on any failure only if such person assumed (under a legally enforceable written agreement) responsibility for the performance of the act to which the failure relates.

"(e) NO DISCRIMINATION BASED ON HEALTH STATUS FOR CERTAIN SERVICES.—

"(1) IN GENERAL.—Except as provided under paragraph (2), group health plans may not deny, limit, or condition the coverage under (or benefits of) the plan based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

"(2) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, group health plans may exclude coverage with respect to services related to treatment of a preexisting condition, but the period of such exclusion may not exceed 6 months. The exclusion of coverage shall not apply to services furnished to newborns.

"(B) CREDITING OF PREVIOUS COVERAGE.—

"(i) IN GENERAL.—A group health plan shall provide that if an individual under such plan is in a period of continuous coverage (as defined in clause (ii)(I)) with respect to particular services as of the date of initial coverage under such plan (determined without regard to any waiting period under such plan), any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage without regard to any waiting period.

"(ii) DEFINITIONS.—As used in this subparagraph:

"(I) PERIOD OF CONTINUOUS COVERAGE.—The term 'period of continuous coverage' means, with respect to particular services, the period beginning on the date an individual is enrolled under a health insurance plan, title XVIII or XIX of the Social Security Act, or other health benefit arrangement (including a self-insured plan) which provides benefits with respect to such services and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

"(II) PREEXISTING CONDITION.—The term 'preexisting condition' means, with respect to coverage under a group health plan, a condition which has been diagnosed or treated during the 3-month period ending on the day before the first date of such coverage without regard to any waiting period.

"(f) DISCLOSURE OF COVERAGE, ETC.—Any person who has provided coverage (other than under title XVIII or XIX of the Social Security Act) during a period of continuous coverage (as defined in subsection (e)(2)(B)(ii)(I)) with respect to a covered individual shall disclose, upon the request of a group health plan subject to the requirements of subsection (e), the coverage provided the covered individual, the period of such coverage, and the benefits provided under such coverage.

"(g) DEFINITIONS.—For purposes of this section—

"(1) COVERED INDIVIDUAL.—The term 'covered individual' means—

"(A) an individual who is (or will be) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1)), and

"(B) the spouse or any dependent child of such individual.

"(2) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 5000(b)(1).".

(b) CLERICAL AMENDMENT.—The table of sections for such chapter 47 of the Internal Revenue Code of 1986

is amended by adding at the end thereof the following new item:

"Sec. 5000B. Failure to satisfy preexisting condition requirements of group health plans.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 1994.

Subtitle D—Health Care Cost Containment

SEC. 251. FEDERAL CERTIFICATION OF MANAGED CARE PLANS AND UTILIZATION REVIEW PROGRAMS.

Title XXI of the Social Security Act, as added by section 211, is amended by adding at the end the following part:

"PART C—FEDERAL CERTIFICATION OF MANAGED CARE PLANS

"FEDERAL CERTIFICATION OF MANAGED CARE PLANS AND UTILIZATION REVIEW PROGRAMS

"SEC. 2114. (a) VOLUNTARY CERTIFICATION PROCESS.—

"(1) CERTIFICATION.—The Secretary shall establish a process for certification of managed care plans meeting the requirements of subsection (b)(1) and of utilization review programs meeting the requirements of subsection (b)(2).

"(2) QUALIFIED MANAGED CARE PLAN.—For purposes of this title, the term 'qualified managed care plan' means a managed care plan that the Secretary certifies, upon application by the program, as meeting the requirements of this section.

"(3) QUALIFIED UTILIZATION REVIEW PROGRAM.—For purposes of this title, the term 'qualified utilization review program' means a utilization review program that the Secretary certifies, upon application by the program, as meeting the requirements of this section.

"(4) UTILIZATION REVIEW PROGRAM.—For purposes of this title, the term 'utilization review program' means a system of reviewing the medical necessity, appropriateness, or quality of health care services and supplies covered under a health insurance plan or a managed care plan using specified guidelines. Such a system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.

"(5) MANAGED CARE PLAN.—

"(A) IN GENERAL.—For purposes of this title the term 'managed care plan' means a plan

operated by a managed care entity as described in subparagraph (B), that arranges for the financing and delivery of health care services to persons covered under such plan through—

"(i) arrangements with participating providers to furnish health care services;

"(ii) explicit standards for the selection of participating providers;

"(iii) organizational arrangements for ongoing quality assurance and utilization review programs; and

"(iv) financial incentives for persons covered under the plan to use the participating providers and procedures provided for by the plan.

"(B) MANAGED CARE ENTITY DEFINED.—For purposes of this title, a managed care entity includes a licensed insurance company, hospital or medical service plan, health maintenance organization, an employer, or employee organization, or a managed care contractor as described in subparagraph (C), that operates a managed care plan.

"(C) MANAGED CARE CONTRACTOR DEFINED.—For purposes of this title, a managed care contractor means a person that—

"(i) establishes, operates or maintains a network of participating providers;

"(ii) conducts or arranges for utilization review activities; and

"(iii) contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

"(6) PARTICIPATING PROVIDER.—The term 'participating provider' means a physician, hospital, pharmacy, laboratory, or other appropriately licensed provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient covered under a managed care plan.

"(7) REVIEW AND RECERTIFICATION.—The Secretary shall establish procedures for the periodic review and recertification of qualified managed care plans and qualified utilization review programs.

"(8) TERMINATION OF CERTIFICATION.—The Secretary shall terminate the certification of a qualified managed care plan or a qualified utilization review program if the Secretary determines that such plan or program no longer meets the applicable requirements for certification. Before effecting a termination, the Secretary shall provide the plan notice and opportunity for a hearing on the proposed termination.

"(9) CERTIFICATION THROUGH ALTERNATIVE REQUIREMENTS.—

"(A) CERTAIN ORGANIZATIONS RECOGNIZED.—An eligible organization as defined in section 1876(b), shall be deemed to meet the requirements of subsection (b) for certification as a qualified managed care plan.

"(B) RECOGNITION OF ACCREDITATION.—If the Secretary finds that a State licensure program or a national accreditation body establishes a requirement or requirements for accreditation of a managed care plan or utilization review program that are at least equivalent to a requirement or requirements established under subsection (b), the Secretary may, to the extent he finds it appropriate, treat a managed care

plan or a utilization review program thus accredited as meeting the requirement or requirements of subsection (b) with respect to which he made such finding.

"(b) REQUIREMENTS FOR CERTIFICATION.—

"(1) MANAGED CARE PLANS.—The Secretary, in consultation with the Health Care Cost Commission, shall establish Federal standards for the certification of qualified managed care plans, including standards related to—

"(A) the qualification and selection of participating providers;

"(B) the number, type, and distribution of participating providers necessary to assure that all covered items and services are available and accessible to persons covered under a managed care plan in each service area;

"(C) the establishment and operation of an ongoing quality assurance program, which includes procedures for—

"(i) evaluating the quality and appropriateness of care;

"(ii) using the results of quality evaluations to promote and improve quality of care; and

"(iii) resolving complaints from enrollees regarding quality and appropriateness of care;

"(D) the provision of benefits for covered items and services not furnished by participating providers if the items and services are medically necessary and immediately required because of an unforeseen illness, injury, or condition;

"(E) the qualifications of individuals performing utilization review activities;

"(F) procedures and criteria for evaluating the necessity and appropriateness of health care services;

"(G) the timeliness with which utilization review determinations are to be made;

"(H) procedures for the operation of an appeals process which provides a fair opportunity for individuals adversely affected by a managed care review determination to have such determination reviewed;

"(I) procedures for ensuring that all applicable Federal and State laws designed to protect the confidentiality of individual medical records are followed; and

"(J) payment of providers for the expenses associated with responding to requests for information needed to conduct a utilization review.

"(2) QUALIFIED UTILIZATION REVIEW PROGRAMS.—The Secretary, in consultation with the Health Care Cost Commission, shall establish Federal standards for the certification of qualified utilization review programs, including standards related to—

"(A) the qualifications of individuals performing utilization review activities;

"(B) procedures and criteria for evaluating the necessity and appropriateness of health care services;

"(C) the timeliness with which utilization review determinations are to be made;

"(D) procedures for the operation of an appeals process which provides a fair opportunity for individuals adversely affected by a utilization review determination to have such determination reviewed;

"(E) procedures for ensuring that all applicable Federal and State laws designed to pro-

tect the confidentiality of individual medical records are followed; and

"(F) payment of providers for the expenses associated with responding to requests for information needed to conduct a utilization review.

"(3) APPLICATION OF STANDARDS.—

"(A) IN GENERAL.—Standards shall first be established under this subsection by not later than 24 months after the date of the enactment of this section. In developing standards under this subsection, the Secretary shall—

"(i) review standards in use by national private accreditation organizations and State licensure programs;

"(ii) recognize, to the extent appropriate, differences in the organizational structure and operation of managed care plans; and

"(iii) establish procedures for the timely consideration of applications for certification by managed care plans and utilization review programs.

"(B) REVISION OF STANDARDS.—The Secretary shall periodically review the standards

established under this subsection, taking into account recommendations by the Health Care Cost Commission, and may revise the standards from time to time to assure that such standards continue to reflect appropriate policies and practices for the cost-effective and medically appropriate use of services within managed care plans and utilization review programs.

"(c) LIMITATION ON STATE RESTRICTIONS ON QUALIFIED MANAGED CARE PLANS AND UTILIZATION REVIEW PROGRAMS.—

"(1) IN GENERAL.—No requirement of any State law or regulation shall—

"(A) prohibit or limit a qualified managed care plan from including financial incentives for covered persons to use the services of participating providers;

"(B) prohibit or limit a qualified managed care plan from restricting coverage of services to those—

"(i) provided by a participating provider; or

"(ii) authorized by a designated participating provider;

"(C) subject to paragraph (2)—

"(i) restrict the amount of payment made by a qualified managed care plan to participating providers for items and services provided to covered persons; or

"(ii) restrict the ability of a qualified managed care plan to pay participating providers for items and services provided to covered persons on a per capita basis;

"(D) prohibit or limit a qualified managed care plan from restricting the location, number, type, or professional qualifications of participating providers;

"(E) prohibit or limit a qualified managed care plan from requiring that items and services be authorized by a primary care physician selected by the covered person from a list of available participating providers;

"(F) prohibit or limit the use of utilization review procedures or criteria by a qualified utilization review program or a qualified managed care plan;

"(G) require a qualified utilization review program or a qualified managed care plan to make public utilization review procedures or criteria;

"(H) prohibit or limit a qualified utilization review program or a qualified managed care plan from determining the location or hours of operation of a utilization review, provided that emergency services furnished during the hours in which the utilization review program is not open are not subject to utilization review;

"(I) require a qualified utilization review program or a qualified managed care plan to pay providers for the expenses associated with responding to requests for information needed to conduct utilization review, other than as provided in standards for qualified managed care plans and qualified utilization review programs;

"(J) restrict the amount of payment made to a qualified utilization review program or a qualified managed care plan for the conduct of utilization review;

"(K) restrict access by a qualified utilization review program or a qualified managed care plan to medical information or personnel required to conduct utilization review;

"(L) define utilization review as the practice of medicine or another health care profession; or

"(M) require that utilization review be conducted (i) by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or (ii) by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered.

"(2) EXCEPTIONS TO CERTAIN REQUIREMENTS.—

"(A) SUBPARAGRAPH (C).—Subparagraph (C) shall not apply where the amount of payments with respect to a block of services or providers is established under a statewide system applicable to all non-Federal payors with respect to such services or providers.

"(B) SUBPARAGRAPHS (L) AND (M).—Nothing in subparagraphs (L) or (M) shall be construed as prohibiting a State from (i) requiring that utilization review be conducted by a licensed health care professional or (ii) requiring that any appeal from such a review be made

by a licensed physician or by a licensed physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered.

"(3) RELATIONSHIP TO MEDICAID PROGRAM.—Nothing in paragraph (1) shall be construed as prohibiting a State from imposing requirements on managed care plans or utilization review programs that are necessary to conform with the requirements of title XIX of the Social Security Act with respect to services provided to, or with respect to, individuals receiving medical assistance under such title.".

TITLE III—HEALTH INSURANCE COSTS FOR SELF-EMPLOYED

SEC. 301. HEALTH INSURANCE COSTS FOR SELF-EMPLOYED.

(a) PERMANENT EXTENSION.—Section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (6).

(b) INCREASE IN DEDUCTION.—Section 162(l)(1) of the Internal Revenue Code of 1986 is amended by striking "25 percent of".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

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